Mental Retardation

A MANUAL FOR GUIDANCE COUNSELLORS

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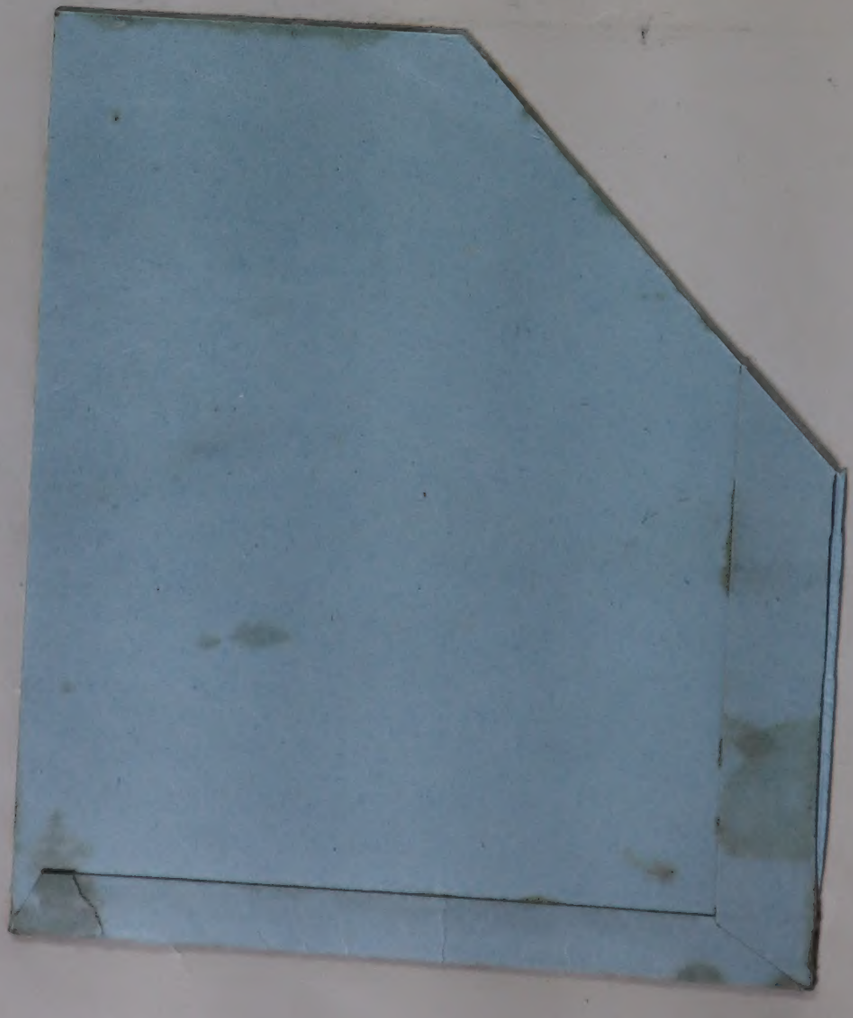

MENTAL RETARDATION
A Manual for Guidance Counsellors

(This manual can also be used by vocational guidance counsellors, social workers, officers of special employment exchange, vocational trainers and employers of the mentally retarded persons)

With Financial Assistance From UNICEF

NATIONAL INSTITUTE FOR THE MENTALLY HANDICAPPED

(Ministry of Welfare, Govt. of India)

MANOVIKAS NAGAR, BOWENPALLY,

SECUNDERABAD-500 011.

MENTAL RETARDATION
A Manual for Guidance Counsellors

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FOREWORD

This manual has been specially prepared for use by the Vocational Guidance Counsellor of the District Rehabilitation Centre Scheme. It has been written under sponsorship of the UNICEF, by a team of professionals from the National Institute for the Mentally Handicapped, Secunderabad, keeping in focus the very specific needs of the D.R.C. scheme counsellor in the rural setting. It adresses itself to the creation of community awareness, parent counselling, screening for identification, vocational guidance and identification of job opportunities for the mentally retarded person. A self evaluation system is built in, for the reader, which will assist him, check his information inputs.

For those of us who have been deeply concerned for over two decades with habilitation programmes for the mentally retarded person, especially in respect to their contributory roles in employment; the dramatic change of events over that period in favour of them is most heart warming. From about ten institutions, three decades ago, delivering special services, to over three hundered institutions today, is growth indeed - but sadly a relatively slow one. Considering the fact that nearly 80% of our population are in villages, with more than 50% most remotely placed; delivery of comprehensive, effective services is one of the greatest challenges we will be facing for many years to come. The purpose of this manual is to assist the DRC functionary to meet this challenge effectively. One cannot doubt that it will.

As a companion volume to the manual on Mental Retardation for psychologists, I am sure that this very compact work will be of considerable assistance to those who would not only have to spread the message of the mentally retarded into the community but also ensure that it is heard and accepted.

NAVAJYOTHI TRUST
MADRAS & BANGALORE

-D.J.K.CORNELIUS-
Hony. DIRECTOR

PREFACE

Vocational training has to keep pace with the employment opportunities, market requirements and socio-economic conditions prevailing in the community. The traditional pattern of vocational training concentrating on trades like candle making, chalk making, mat weaving, basket weaving and envelope making, may not prepare a person with mental handicap for employment in the market. In order to encourage independence, it is necessary that an adult mentally handicapped person should find a job near his place of residence or at a place where he can easily commute by using local transport services. Experiments made within our country clearly demonstrate that persons even with moderate or severe mental retardation can be gainfully employed under sheltered workshop conditions, self-employment and open competitive employment. It is necessary that the training should be concentrated in those aspects which are directly required for employment. Some kind of support may be required to enable the person with mental handicap to continue on the job. Given these facilities, it is heartening to note that the persons with mental handicap are second to none. With training they can use the screw driver faster, they can tighten the nuts quicker and they can carry out the task to perfection.

In the rural areas, one can find several persons with mental handicap already well adjusted and rehabilitated. It would perhaps be appropriate to find out the factors which facilitate rehabilitation of such persons so that persons with severe mental retardation could also be given similar kind of work opportunities and training for rehabilitation. It would be desirable to find job placement for the rural persons with mental handicap in their own village as a self employment activity. It should be a challenge to the professionals working with the mentally handicapped persons to find out suitable occupation which can be performed in their natural surroundings.

(Dr. D.K. MENON)
Director, NIMH

December, 1988

About the Manual

This manual is written to help the vocational guidance counsellors of the district rehabilitation centre scheme. This is one of a series of four manuals intended to guide the workers in the rural areas in the early identification and management of mental handicap in children. Persons working in the area of mental retardation such as soical workers, vocational trainers, officers of the special employment exchange and such other persons may also find this manual useful as it covers general information on mental retardation. The manual consists of five chapters giving information on definition and classifcation, causes and prevention, identification and referral, management and vocational training and jobs placement.

Keeping in view the functions of the vocational guidance counsellors, at the district rehabilitation centre, the chapters planned cover the community awareness, parent counselling, vocational training and job placement. The details of various jobs that can be undertaken by the mentally retarded persons and a checklist for prevocational level assessment which is currently under field trial at NIMH are given in the last chapter.

This manual is complementary to the manual, Mental Retardation - A manual for psychologists. The first three chapters are common in both the manuals. For details of psychological assessment, skill training and behaviour management, the guidance counsellor should refer the manual for psychologists. After reading the manual, the guidance counsellor will be in a position to identify persons with mental retardation, and guide the parents appropriately on the management. He will also be in a position to choose appropriate jobs in the rural area for the mentally retarded persons. Each chapter has instructional objectives at the beginning and a self evaluation questionnaire at the end. It is hoped that the reader will find the manual beneficial in acquiring knowledge and skills to guide the mentally retarded persons in the community.

T.MADHAVAN
Chief Investigator &
Project Coordinator

December, 1988

Acknowledgements

We express our sincere thanks to many persons of NIMH who gave their valuable suggestions on the first three drafts of this manual. We are thankful to the project advisory committee members Prof. N.K.Jangira, Mr P.Jayachandran and Dr. K.Mohan Isaac for their constant guidance. Our thanks are due to UNICEF for the financial assistance to carry out the project. We extend our thanks to the Principal, staff and students of the Post Graduate College of Social Work, Hyderabad for their help in field testing the manual.

We thank Sri D.J.K.Cornelius, Honorary Director, Navajyothi Trust, Madras and Bangalore for his gracious foreword. We thank Ms. Vijayalakshmi Myreddi and Ms. Shyamala Kumari, research staff during the initial phases of this project for their kind help. We thank Mr. K.Nageswar Rao, artist for his patient work in the preparation of illustrations which had to undergo number of changes. We profusely thank Mr. Subramanyam and his band of workers from New Era Printpacks, Secunderabad for their interest and zeal in making this manual come out in print. The help rendered by Mr. A.Venkateswara Rao and Miss P.Nagarani in typing the manuscripts is gratefully acknowledged.

T.MADHAVAN

CHAPTER - 1

DEFINITION AND CLASSIFICATION

OBJECTIVES :

On completing this chapter the guidance counsellor will be able to:

1. Define mental retardation.
2. Explain the components of mental retardation.
3. Specify medical, psychological and educational classification.
4. Describe the prevalence of mental retardation in India.
5. List the functional level of various groups of mentally retarded persons.

CHAPTER - 1

DEFINITION AND CLASSIFICATION

Mental Retardation, mental deficiency, mental subnormality and mental handicap are the terms used to refer to the same condition. The terms used in the past such as amentia, idiocy, feeble minded, moron, imbecile and oligophrenia are now obsolete.

DEFINITION:

There are many definitions of mental retardation. The most comprehensive among them is the one given by the American Association on Mental Retardation (AAMR). The definition as given in 1983 is:

> MENTAL RETARDATION REFERS TO SIGNIFICANTLY SUBAVERAGE GENERAL INTELLECTUAL FUNCTIONING, RESULTING IN OR ASSOCIATED WITH CONCURRENT IMPAIRMENTS IN ADAPTIVE BEHAVIOUR, AND MANIFESTED DURING THE DEVELOPMENTAL PERIOD.

'GENERAL INTELLECTUAL FUNCTIONING' is defined as the results obtained by the administration of standardized general intelligence tests developed for the purpose, and adapted to the conditions of the region / country.

'SIGNIFICANTLY SUBAVERAGE' is defined as IQ of 70 or below on standardized measures of intelligence. The upper limit is intended as a guideline; it could be extended to 75 or more, depending upon the reliability of intelligence test used.

'ADAPTIVE BEHAVIOUR' is defined as the degree with which the individual meets the standards of personal independence and social responsibility expected of his age and cultural group. The expectations of adaptive behaviour vary with the chronological age. The deficits in adaptive behaviour may be reflected in the following areas:

- During infancy and early childhood in

1. Sensory and motor skill development
2. Communication skills (including speech and language)
3. Self help skills
4. Socialization

- During childhood and adolescence in

5. Application of basic academic skills to daily life acitivities.

6. Application of appropriate reasoning and judgement in the mastery of the environment.

7. Social skills

- During late adolescence and adult life in

8. Vocational and social responsibilities and performances.

'DEVELOPMENTAL PERIOD, is defined as the period of time between conception and the 18th birthday.

CLASSIFICATION:

The Objectives of classification are:-

1. Assistance in the use of an acceptable, uniform system throughout the world,

2. Helping in diagnostic, therapeutic and research purposes, and

3. Facilitating efforts at prevention.

There are different methods of classification of mental retardation. They are medical, psychological and educational as given in table - I. The medical classification is based on the cause, the psychological classification on the level of intelligence and the educational classification on the current level of functioning of the mentally retarded person / child.

Table - I

CLASSIFICATION OF MENTAL RETARDATION

Medical	Educational
1. Infections and Intoxications	1. Educable
2. Trauma or physical agent	2. Trainable
3. Metabolism or Nutrition	3. Custodial
4. Grossbrain disease (post natal)	
5. Unknown prenatal influence	Psychological
6. Chromosomal abnormality	1. Mild - (50-70)
7. Gestational disorder	2. Moderate - (35-49)
8. Psychiatric disorder	3. Severe - (20-34)
9. Environmental influence	4. Profound - below 20
10. Other influences	

The various classifications provide an understanding of the level at which the mentally retarded person functions with respect to his education, appropriate behaviour and the degree of his independence. The characteristics of the mentally retarded persons vary depending upon the level of retardation. The terms currently used to describe the various degrees of mental retardation are mild, moderate, severe and profound. Table- II describes the characteristics of persons with various degrees of mental retardation.

Every mentally retarded person may not exactly fit in the above description. There may be specific strengths and weaknesses in each person. The description of the various groups of mentally retarded persons as given in the table may sometimes overlap in a given case.

Before labelling a person as mentally retarded, especially in the mild category, certain factors have to be considered. Members belonging to low socio-economic groups and certain cultures may score low on standard tests of intelligence and thus may be termed as mentally retarded. However, they will be functioning within normal limits according to their culture's criteria. Therefore, one must be cautious before labelling a person as mentally retarded.

The maximum mental age a person can attain with the various degrees of mental retardation is given in Figure 1.

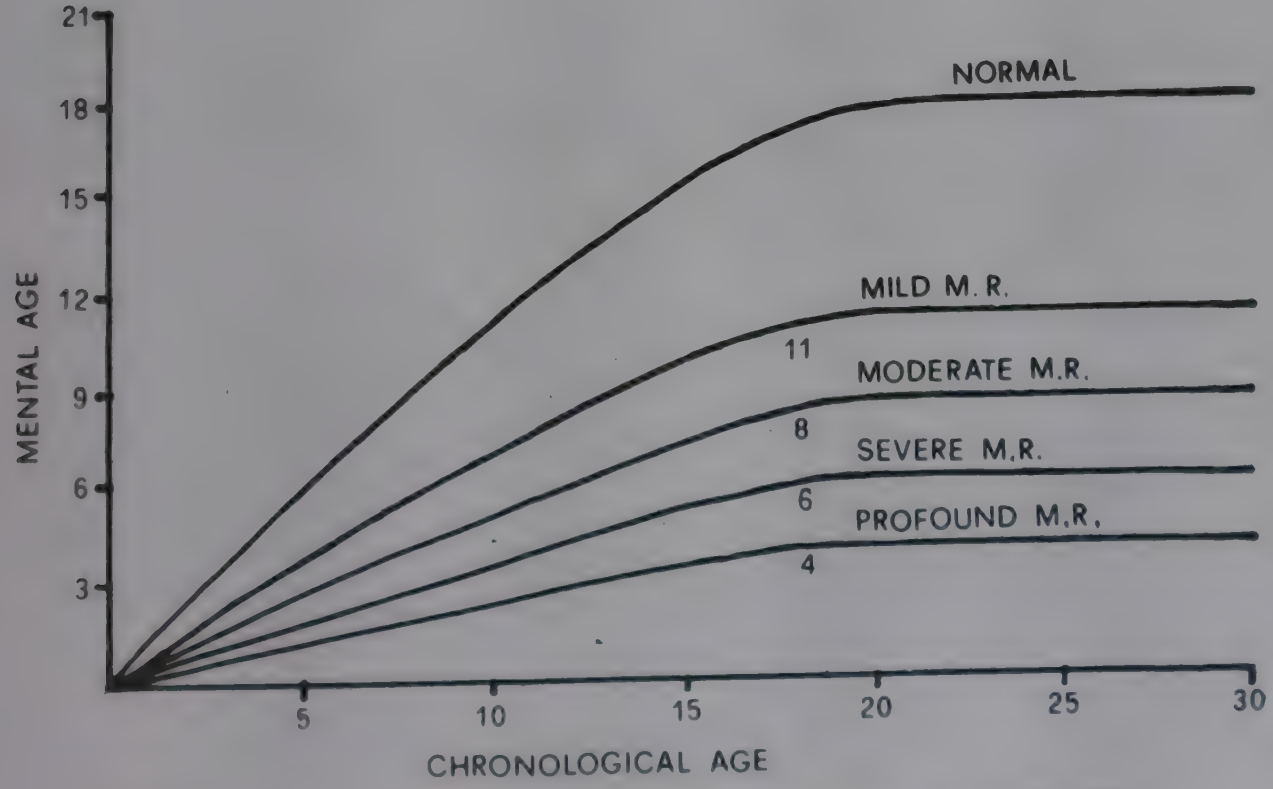


FIG – 1 MENTAL AGE VS DEGREE OF MENTAL RETARDATION

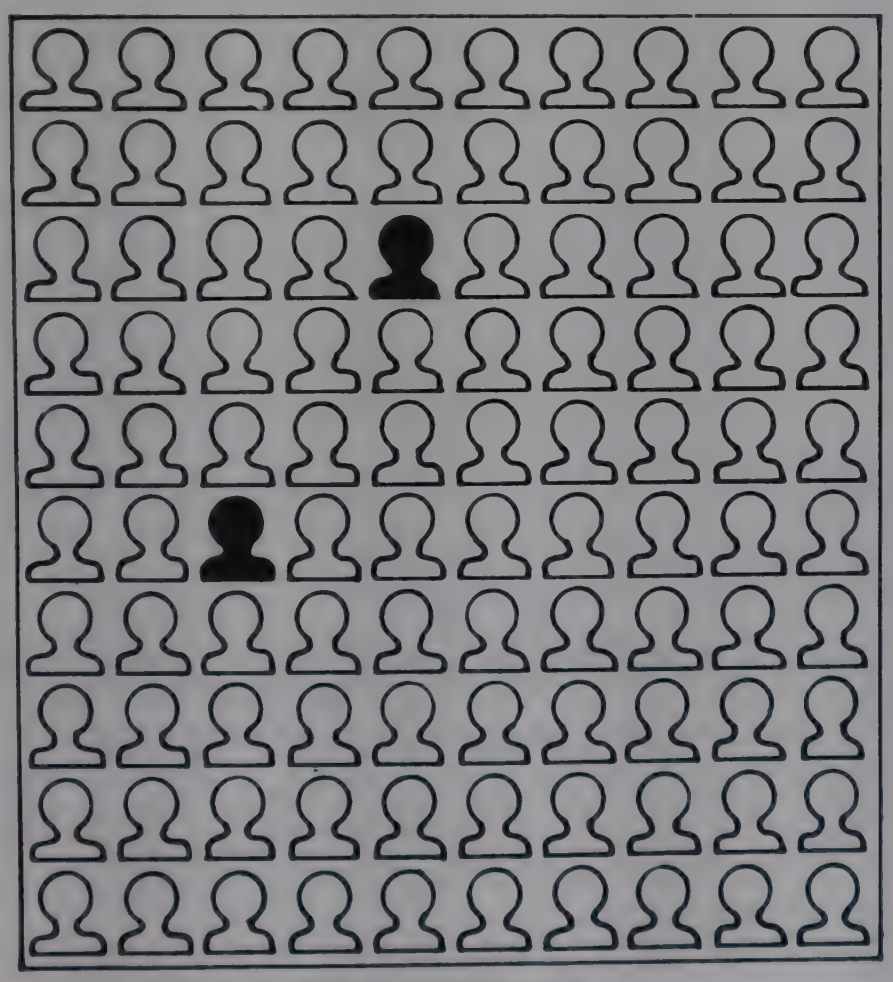
Table - II : CHARACTERISTICS OF PERSONS WITH VARIOUS DEGREES OF MENTAL RETARDATION

Description \ Severity level	Mild	Moderate	Severe	Profound
Preschool 0-5 yrs	Can develop social and communication skills, minimal retardation in sensori motor areas, often not distinguished from normal until late age.	Can talk or learn to communicate; poor social awareness; fair motor development, profits from training in self help; can be managed with moderate supervision.	Poor motor development, speech minimal; generally unable to profit from training in self-help; little or no communcation skills.	Gross retardation; minimal capacity for functioning in sensori motor areas; needs nursing care.
School age 6-20 yrs Training and Education	Can learn academic skills upto approximately 6th grade level by late teens; can be guided toward social confirmity.	Can profit from training in social and occupational skills; unlikely to progress beyond 2nd grade level in academic subjects; may learn to travel alone in familiar places.	Can talk or learn to communicate; can be trained in elemental health habits; profits from systematic habit training.	Some motor development present; may respond to minimal or limited training in self help.
Adult 21 and over Social and vocational adequacy	Can usually achieve social and vocational skills adequate to minimum self support but may need guidance and assistance when under unusual social or economic stress.	May achieve self maintenance in unskilled or semi-skilled work under sheltered conditions; needs supervision and guidance when under mild social or economic stress.	May contribute partially to self maintenance under complete supervision; can develop self protection skills to a minimal useful level in controlled environment.	Some motor and speech development; may achieve very limited self-care; needs nursing care

Adapted from Mental Retardation Activities of the U S Department of Health, Education and Welfare, P.2 United States Government Printing Office, Washington D.C., 1963. Printed in Modern Synopsis of Comprehensive Text Book of Psychiatry/IIIThird Edition - Eds - Herold. I. Kaplan and Benjamin, J.Sadock Williams and Wilkins Company - Baltimore - 1981.

PREVALENCE:

It is generally considered that 2% of the population constitute persons with mental retardation. However, there is no systematic National Survey conducted to determine the prevalence of mental retardation in India. Recently, it has been estimated that in India, there are about 20 million persons who are mildly retarded and about 4 million persons who are moderately and severely retarded. Table - III gives the details of various prevalence studies conducted in India. It can be observed from the table that the figures for prevalence of mental retardation in India vary from 0.22 to 32.7 per thousand population. This is because the methodology, the time, the type of population and the sample size were not uniform in all the studies and the operational definition of a case of mental retardation varied from one study to the other. In addition, these surveys were carried out with the intention of finding out the psychiatric morbidity and not mental retardation per se.



MENTAL RETARDATION IN INDIA — 2%

Table - III : PREVALENCE OF MENTAL RETARDATION IN INDIA

SL. NO.	Investigators	Year	Place	Population Studied	Type of Community	Prevalence Per 1000 Population
1.	Surya et al	1964	Pondicherry	2,731	Urban Slum	0.7
2.	Sethi et al	1967	Lucknow	1,733	Urban	22.5
3.	Gopinath	1968	Bangalore	423	Rural	4.72
4.	Dube	1970	Agra	29,468	Mixed	3.7
5.	Elnagar	1971	Hooghly	1,383	Rural	1.4
6.	Sethi et al	1972	Lucknow	2,691	Rural	25.3
7.	Varghese	1973	Vellore	2,904	Urban	3.2
8.	Sethi et al	1974	Lucknow	4,481	Urban	10.5
9.	Thacore et al	1975	Lucknow	2,696	Urban	14.0
10.	Nandi	1975	Calcutta	1,060	Rural	2.8
11.	Nandi	1976	Calcutta	1,078	Rural	3.7
12.	Carstairs & Kapur	1976	Kota	9,111	Rural	10.0
13.	Nandi	1980	Calcutta	4,053	Rural	8.6
14.	Nandi	1980	Calcutta	1,864	Mixed	10.7
15.	Shah	1980	Ahmedabad	2,712	Urban	1.8
16.	Isaac & Kapur	1980	Bangalore	4,209	Rural	3.6
17.	Shalini	1982	Bangalore	451	Rural	32.7
18.	ICMR	1983	Bangalore	35,548	Rural	1.32
19.	ICMR	1983	Baroda	39,655	Rural	2.33
20.	ICMR	1983	Calcutta	34,582	Rural	0.58
21.	ICMR	1983	Patiala	36,595	Rural	0.22

Summary

1. The AAMR definition of mental retardation gives the components of mental retardation as significantly subaverage intelligence, impairments in adaptive behaviour and manifestation before the age of 18 years.

2. The medical, psychological and educational classification of mental retardation are based on the cause, intellectual level and current level of functioning respectively. The functional level of each of the groups of mentally retarded persons is given.

3. The prevalence of mental retardation in India is estimated at 2% of population. There are a number of prevalence studies which give figures varying from 0.22 to 32.7 per thousand population.

Self Evaluation - I

1. The components of AAMR definition of mental retardation are

   a. _____ b. _____ c. _____

2. Approximately _____% of population in India is considered mentally retarded.

3. There are variations in the prevalence of mental retardation in India. The reasons for them could be lack of uniformity in

   a.

   b.

   c.

4. Match the following:

1. IQ level	a. medical	( )
2. level of functioning	b. psychological	( )
3. cause of MR	c. adaptive behaviour	( )
4. deficient in MR	d. educational	( )

5. Match the following:

1. severe	a. 50-70	( )
2. mild	b. 35-49	( )
3. moderate	c. below 20	( )
4. profound	d. 20-34	( )

6. Study the following statements carefully and say whether they are true or false.

1. A five year old child with mild mental retardation cannot be distinguished from a normal child of five years in many areas of development. True/False

2. A 15 year old person with moderate mental retardation can go beyond 5th grade level in academic subjects. True/False

3. A 21 year old person with severe mental retardation can be trained in all the vocational skills and can support himself and his family. True/False

4. A 12 year old child with profound mental retardation will respond for training in self help skills. True/False

5. A 25 year old person with mild mental retardation can pass pre-university examination. True/False

CHAPTER-2

CAUSES AND PREVENTION

OBJECTIVES :

On completing this chapter, the guidance counsellor will be able to:

1. List the prenatal, perinatal and postnatal causes of mental retardation.

2. Describe the measures that can be adopted to prevent mental retardation.

3. Explain the problems associated with mental retardation - epilepsy, nut ritional disorders, hyperkinesis, psychiatric disturbances and multiple handicaps.

CHAPTER - 2

CAUSES AND PREVENTION

CAUSES : Mental retardation is caused by a number of factors. They can be broadly grouped into prenatal, perinatal and postnatal factors.

Prenatal Causes

1. Chromosomal disorders: There are 23 pairs of chromosomes in each human cell. Every person gets half the number of chromosomes from each parent. Errors in chromosomes produce conditions with medical problems and most of these conditions cause mental retardation. The error may be in the number of chromosomes being too many or too few, or the error may be in the structure of the chromosome. One common condition due to error in the chromosome number is Down's syndrome. In this condition generally there is an extra chromosome at number 21. Because of this the persons with Down's syndrome have striking physical features such as widely set slanting eyes, depressed nasal bridge, open mouth, thick tongue, low set small ears, short limbs, short fingers, characteristic palmar creases etc.

2. Genetic disorders: Defect in the genes, transmitted from the parent to the offspring can result in certain conditions with mental retardation. The parents may not have the defect or, even if the parents have the defect, they may not manifest the condition. A number of genetic disorders are recognised. In some of these genetic disorders, there is a metabolic abnormality and a specific enzyme may be deficient or absent. This results in accumulation of specific substance in the body including the brain resulting in brain damage. This causes mental retardation. Some of the examples of such genetic disorders are phenylketonuria, mucopolysaccharidosis, lipidoses etc.

3. Infections in the mother, especially those during the first three months of pregnancy can damage the developing brain of the foetus. Some of the infections that affect the foetus are rubella (german measles), herpes and cytomegalic inclusion disease; toxoplasmosis, syphilis and tuberculosis.

Down Syndrome, phenylketonuria, Mucopolysaccharidosis, Lipidoses, Rubella, Herpes, Toxoplasmosis, Syphilis & Tuberculosis, Diabetes Mellitus, High blood pressure & chronic problems in the Kidneys → Malnutrition, Hypothyroidism → X-ray, Harmful drugs, Hormones, Fits, Accidents → Hydrocephalus, Microcephaly

4. Maternal diseases such as diabetes mellitus and high blood pressure; chronic problems in the kidneys and malnutrition in the mother can damage the growing foetus. Conditions such as hypothyroidism in the mother may lead on to the birth of a child with cretinism. Excess of thyroid in the mother (hyperthyroidism) can produce defects in the central nervous system of the growing foetus leading to mental retardation.

5. Exposure to X-ray in the early months of pregnancy, using harmful drugs especially those used in the treatment of cancer, some of the antiepileptic drugs and hormones can damage the growing foetus. Untreated fits in the mother and accidents from falls resulting in injury to the abdomen can damage the growing foetus and lead on to mental retardation.

6. Congenital defects of the central nervous system such as hydrocephalus, microcephaly and a number of defects of the brain and spinal cord are associated with mental retardation.

Perinatal Causes

The following are some of the perinatal causes of mental retardation:

1. Premature birth (being born between 28 weeks and 34 weeks) due to various causes.

2. Low birth weight babies (less than 2 kg).

3. Lack of respiration immediately after birth (the brain suffers irreversible damage if it is deprived of oxygen for 4 or 5 minutes).

4. Trauma to the head of the new born due to factors such as excessive moulding due to disproportion between foetal head and birth canal or prolonged labour or delivery by improper use of instruments.

5. Abnormal position of the foetus in the uterus.

6. Excessive coiling of umbilical cord around the neck of the foetus.

7. Abnormal position of the placenta.

8. Toxemia of pregnancy with high blood pressure and fits in the mother.

9. Haemorrhage or bleeding in the brain of the new-born due to various causes.

10. Severe jaundice in the new-born due to various causes.

11. Medicines administered to the mother such as anaesthetics and pain killers.

Postnatal Causes

1. Malnutrition in the child: Brain is vulnerable to malnutrition during 12-18 weeks of foetal life when multiplication of nerve cells is very active and from birth to the end of 2nd year of life. Inadequate intake of proteins and carbohydrates during this period predisposes to mental retardation.

2. Infections in the child such as meningitis or encephalitis (brain fever) can lead on to mental retardation.

3. Repeated fits in the child can damage the brain and lead on to mental retardation.

4. Any injury to the brain from accidents or falls can lead on to mental retardation.

PREVENTION

Having known the causes, let us see how they can be prevented. Prevention can be broadly grouped into three stages:

1. Prenatal period 2. Perinatal period 3. Post natal period

Prenatal Period

a. Periodic medical check-up for the pregnant woman is very important. The pregnant woman should have adequate nutrition. If there is history of deformities in previous deliveries or if there are repeated abortions she should be admitted to a hospital with good facilities for further investigation.

b. A pregnant woman should avoid taking drugs when medically not prescribed.

c. If a pregnant woman prefers an abortion she should get it done by a qualified doctor and not resort to local methods.

d. A pregnant woman should not be exposed to radiations such as X-rays especially in the early stages of pregnancy.

e. A pregnant woman should be immunized against diseases such as german measles and tetanus.

f. If the pregnant woman has high blood pressure or repeated fits, she must be under continuous care of a qualified doctor.

g. Hard work such as carrying heavy loads, especially in the fields, and other accident prone activity such as walking on slippery grounds, climbing on narrow stools and chairs should be avoided during pregnancy.

h. If there is a history of a child with genetic problem, the pregnant woman should be sent to a place where tests to detect such abnormalities in the foetus are available.

Perinatal Period

a. Many cases of mental retardation occur due to damage to the brain during delivery. Difficulties during the delivery of the child is one of the most common causes of mental retardation in developing countries like India since specialized attention is not always available. Proper care during delivery can help in preventing mental retardation.

b. Deliveries must be conducted by trained personnel. Complications must be detected early and a qualified doctor informed about the impending condition.

c. In case of abnormal positioning of the foetus in the uterus the delivery must be conducted by a qualified doctor.

d. In case a baby is blue when born or if the birth cry is delayed, the baby must be given oxygen immediately. It must be ensured that the baby breathes properly.

e. If any congenital abnormality is noted, the child should be sent to a specialist for management.

Postnatal Period

a. A child should be immunized against all infectious diseases such as diphtheria, polio, tetanus, measles, tuberculosis, and whooping cough.

b. If a child has high fever, the temperature should be brought down immediately by cold sponging and antipyretics.

c. If a child gets fits, drugs must be given to control them and further fits.

d. In case of epidemics especially those of brain fever (encephalitis), the child should be given adequate care and not be exposed to active cases of encephalitis. Care should be taken to see that food and water are not contaminated.

e. A child should be given adequate nutritious food, because malnutrition during developmental period is said to impair brain growth.

f. In case the child is born with a small/big head or stiff limbs he should be taken to a doctor to prevent further disabilities.

g. In case the child has gross delay in attaining the proper milestones during the first six months, the child should be tested by an expert for a thorough evaluation of developmental disabilities.

Apart from the above mentioned aspects the following factors should also be kept in mind.

a. It is desirable to avoid child bearing before the age of 18 years and after the age of 35 years.

b. It is desirable to prevent consanguinous marriages, i.e. marriages among cousins especially when there is a history of mental retardation in the family.

c. In case there is a mentally retarded person in a family, due to a hereditary cause, the parents should be advised regarding the future risk of having such children.

Associated Problems in Mental Retardation

In addition to the deficits in intelligence and adaptive behaviour, some mentally retarded persons have medical problems or associated handicaps. Some of the most common medical problems encountered in the mentally retarded persons are epilepsy, hyperkinesis, physical handicaps, nutritional disorders and psychiatric problems such as autism, psychosis and neurotic disturbances.

Epilepsy

About forty percent of mentally retarded persons, have convulsions of one type or the other. The convulsions vary in their frequency, duration, and type depending upon the nature of brain damage. Fits are more common in persons with severe and profound mental retardation than in those with mild or moderate mental retardation.

If a mentally retarded person is found to have fits, the following points must be taken note of:

1. A detailed history about the fits, its nature, duration, frequency, type, time of onset, premonitory symptoms, and symptoms after the fits stop, must be taken.
2. The person should be referred to a doctor immediately with all the above information and the anticonvulsant medication advised by the doctor should be strictly followed.
3. It must be emphasised on the parents that fits can be cured with medicines and regular medication is necessary and the person must be periodically sent for medical check-up.
4. Presence of fits impairs learning process and hence while training a mentally retarded person in various activities or skills, a note must be made about occurence of fits during the training process.
5. When a mentally retarded person who has epilepsy, is being considered to be placed in a job, attention must be paid to the nature of job that is being chosen. Places of work where machinery or cutting tools are used, or work related to water or high rise buildings should be avoided.

Nutritional Disorders

1. Brain has active growth during the first trimester of pregnancy and from birth till the end of 2 years after birth.
2. Malnutrition especially during the first two years of life can seriously impair brain development.
3. Continuing the child on breast milk alone beyond 6 months and not adding supplementary food restricts the intake of proteins, fats, vitamins and minerals leading on to growth retardation.
4. Some mentally retarded children, because of their inability to chew and swallow are not given the required quantity of food and this further leads on to the delay in growth.
5. Some of the common nutritional disorders are protein calorie malnutrition, deficiency of vitamins belonging to A & B group

Hyperkinesis

1. Some of the mentally retarded children exhibit hyperkinetic behaviour and this generally occurs in children with brain damage.
2. The features of hyperkinesis are being excessively active, distractible, having poor attention span, restlessness, lack of inhibition and poorly organised and poorly coordinated activity.
3. They are impulsive, aggressive and show fluctuations in their mood.
4. Presence of hyperkinetic behaviour impairs the learning process seriously.
5. The intensity of hyperkinetic behaviour can be brought down with medication.
6. While assessing a child with hyperkinesis, careful attention should be given to the situation in which he is hyperactive. Sometimes behaviour disturbances due to provoking factors in the environment, poor parental control or lack of stimulating environment can be confused with hyperkinesis. Detailed history and careful observation of the child is necessary in making such a differentiation.

Psychiatric Disturbances

Some of the psychiatric disturbances in mental retardation are autistic behaviour, psychotic states such as schizophrenia, mania and depression and neurotic states such as anxiety neurosis, and hysterical neurosis. Features similar to autism are present in children with mental retardation where as the psychotic and neurotic states are more common with adult mentally retarded persons. Diagnosis of mental illness in mental retardation needs an expert, detailed psychiatric evaluation. In case the following symptoms are noticed in a person with mental retardation, refer him to a psychiatrist.

1. Remaining aloof for long periods of time.

2. Muttering to self and food refusal.

3. Unprovoked aggressive behaviour.

4. States of extreme elation or depression of mood.

5. Lack of sleep or disturbed sleep rhythm.

6. Sudden change in behaviour.

A number of conditions can be mistaken for mental retardation. They are given at Table-1.

TABLE - 1 : CONDITIONS MISTAKEN FOR MENTAL RETARDATION

1. Early infantile autism
2. Child with hearing impairment
3. Child with emotional disturbance
4. Cultural deprivation and lack of stimulation
5. Specific learning disabilities
6. Childhood psychosis
7. Child with visual handicap
8. Child with physical handicap

Multiple Handicaps

An individual with more than one of the four handicaps viz. physical, hearing, vision and mental, is classified under multiple handicap. Children with multiple handicaps grow, learn and develop much more slowly than any other group of children with single handicap. They need intensive training to perform even the most basic skills necessary for survival.

Cerebral Palsy with mental retardation is one of the commonest forms of multiple handicap. Cerebral Palsy is a condition characterised predominently by motor disturbances and incoordination of movements of various degrees of severity. This is a non progressive condition and occurs due to damage to certain areas in the brain.An example of such a condition is described below.

Multiple Handicap
Case History

Anita is a 8 year old child. She was brought two years back with the complaints of inability to hold objects, drooling, squint eyes and stiffness of limbs. History revealed that the child was born out of a difficult forceps delivery and her birth cry was delayed. The child attained neck control only at the age of 1 year and rolled over by 2 years. After detailed clinical examination, a diagnosis of cerebral palsy due to birth anoxia was made. On psychological assessment she was found to have an IQ of 30. The educational assessment revealed that Anita was not able to feed herself, could not express her toilet needs, could not remove or put on her clothes and was dependant on someone for all self help skills. She could recognise her parents. She could not recognise objects of everyday use.She was as a child with severe mental retardation with cerebral palsy. The parents were informed about the child's condition and counselled on the need for prolonged physiotherapy, speech therapy and intensive training in various self help skills. A management plan was developed for the child and the parents were guided on home training, in addition to the regular training in the organisation for the mentally retarded children. After 2 years of intensive training Anita is able to sit, stand with support, speak a few meaningful words, indicate her toilet needs, feed herself and remove her clothes. Her drooling has stopped and she is more cheerful than before. As parents are fully aware of the child's condition they cooperate with the professionals in training the child.

Multiply handicapped individuals constitute a heterogenous group. The differences among these individuals are greater than their similarities. Their disabilities are of various combinations and intensity. These may include extreme deficits in intellectual functioning, motor development, speech and language development, visual and auditory functioning and adaptive behaviour. Because of the multiple impairments, they look noticeably different from other individuals and their behaviour looks deviant.

It is difficult to identify the intensity of each of the handicaps in a multiply handicapped person. It is also difficult to determine the ways in which combinations of disabilities affect a person's behaviour. Accurate assessment of the various handicaps is necessary in such children before a management plan is drawn out for them.

Summary

1. There are a number of causes for mental retardation which can be grouped into prenatal, perinatal and postnatal causes. The most common causes in India in the three respective periods are Down's syndrome, difficulties during delivery and infections of the brain such as encephalitis and meningitis.

2. The various preventive measures during the various periods are described.

3. Some of the mentally retarded persons have associated handicaps or medical problems such as epilepsy, hyperkinesis, nutritional disorders or psychiatric disturbances.

Self Evaluation - II

1. Which one of the following is not a prenatal cause of mental retardation.

   a. Exposure to X-ray

   b. Birth anoxia

   c. Rubella

   d. Chromosomal abnormality

2. Which one of the following is the most common cause of mental retardation in India

   a. Diabetes in the mother

   b. Difficulties during delivery of the child

   c. Jaundice in the mother

   d. German measles in the mother

3. Mental retardation can be caused by

   a. Ill treatment of mother during pregnancy

   b. Interacting with mentally retarded persons

   c. Pregnancy after 35 years

   d. Black magic

4. List four preventive measures against mental retardation during the post-natal period

   a. _____

   b. _____

   c. _____

   d. _____

5. In a mentally retarded person with fits

   a. Fits cannot be controlled

   b. Behaviour problems are always present

   c. Frequent fits impair learning process

   d. None of the above

6. Hyperkinesis includes all of the following except

   a. Excessively active

   b. Distractibility and short attention span

   c. Vacant stare

   d. Lack of inhibition and poorly coordinated activity

7. List four conditions which can be mistaken for mental retardation

   a. _____

   b. _____

   c. _____

   d. _____

8. One of the commonest forms of multiple handicap is

   a. Down's syndrome

   b. Cerebral Palsy with mental retardation

   c. Learning disabilities

   d. Mental retardation with microcephaly

CHAPTER-3

IDENTIFICATION AND REFERRAL

OBJECTIVES :

On completing this chapter the guidance counsellor will be able to:

1. List 25 normal milestones of development relevant to Indian situations.
2. Use the three screening schedules for mental retardation
3. Describe the referral procedures.

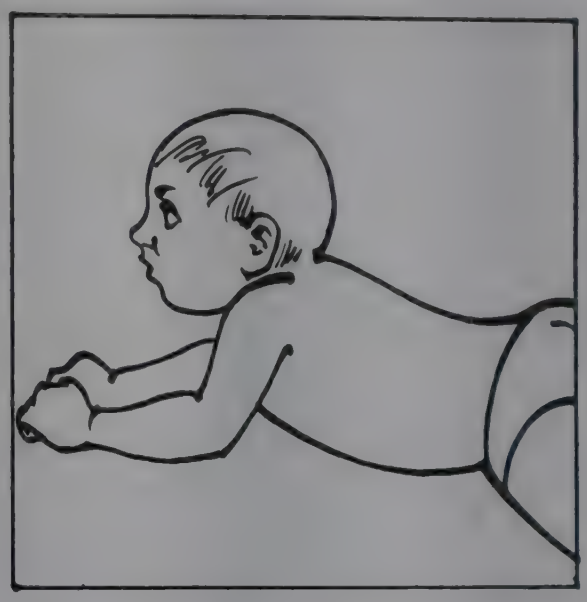
CHAPTER-3

IDENTIFICATION AND REFERRAL

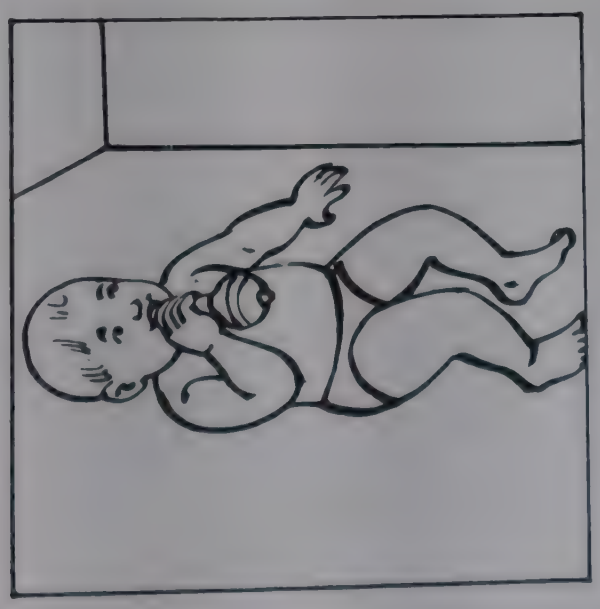
Child Development

Growth and development of children follow a pattern. Every child passes through certain steps at particular time in his life. These stages are called milestones of development. It is important to know the normal milestones of development as it helps in identifying children who have delayed development. Some of the common milestones of development and the approximate age of their attainment relevant to Indian situations are given below. It should be kept in mind that some children may skip few of the stages.

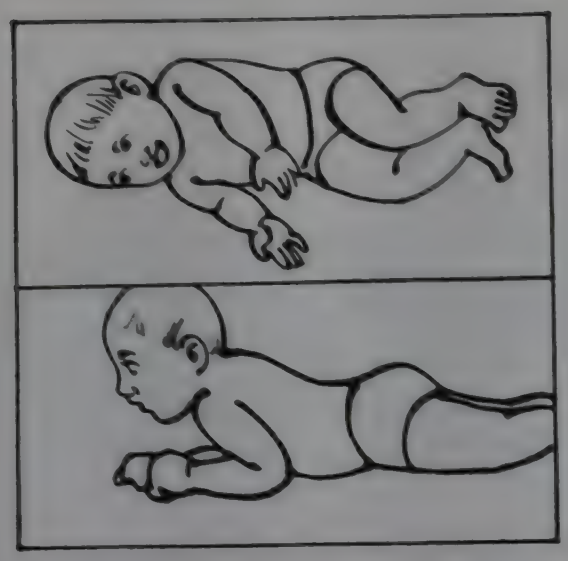
Smiles at others
4 months



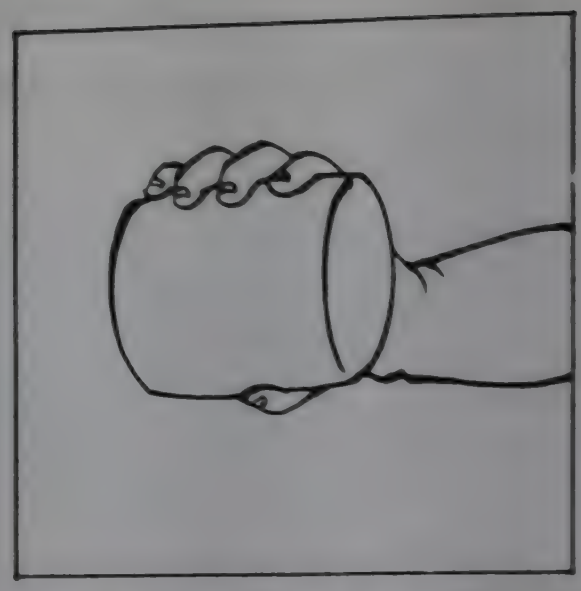
Holds head erect
4 months.



Puts objects into mouth
4 months.



Rolls from back on to stomach
6 months



Uses whole palm to grasp
7 months

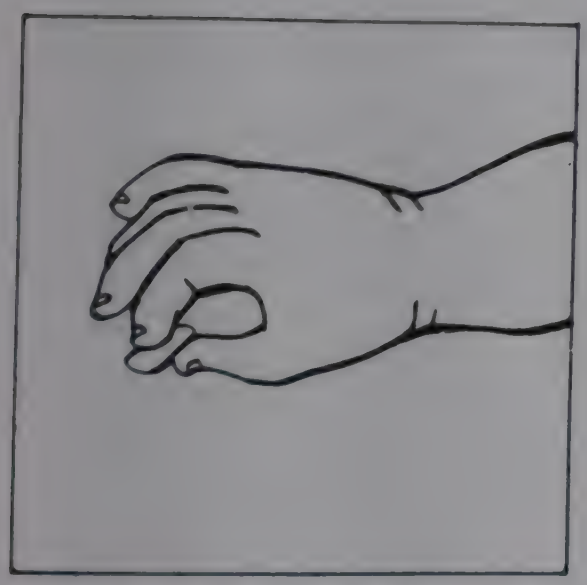
Makes sounds 'anna', 'ad dada'
7 months

Sits without support
8 months

Responds to name
10 months

Crawls
10 months

Stands by holding on to an object 10 months



Holds an object with thumb and index finger 10 months

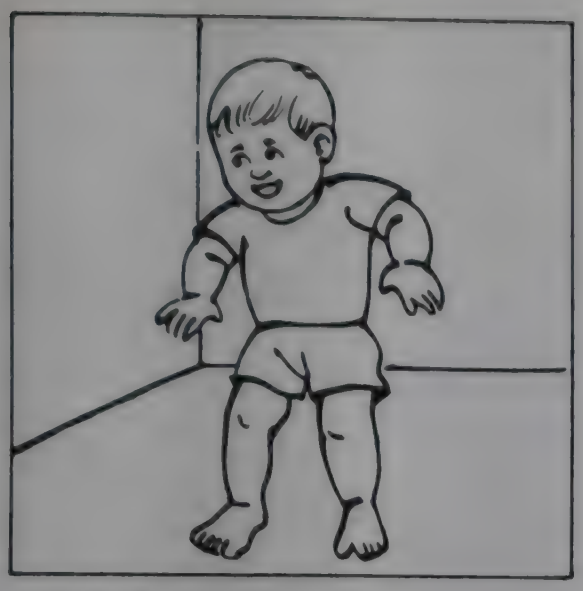
Stands without support 10 months

Says 'amma', 'akka', 'atha', meaningfully 15 months

Normal Milestones of Development

S.No.	MILESTONE	AGE*
1.	Smiles at others	4 months
2.	Holds head erect	4 months
3.	Puts objects into mouth	4 months
4.	Rolls from back on to stomach	6 months
5.	Uses whole palm to grasp	7 months
6.	Makes sounds 'anna', 'ad dadda'	7 months
7.	Sits without support	8 months
8.	Responds to name	10 months
9.	Crawls	10 months
10.	Stands by holding on to an object	10 months
11.	Holds object with thumb and index finger	10 months
12.	Stands without support	10 months
13.	Says 'amma', 'akka', 'atta', meaningfully	15 months
14.	Walks without support	15 months
15.	Tells own name	18 months
16.	Drinks by self from a glass	21 months
17.	Shows body parts when named	24 months
18.	Indicates toilet needs	24 months
19.	Speaks in small sentences	30 months
20.	Unbuttons clothes	36 months
21.	Gives meaningful verbal answers to simple questions	36 months
22.	Differentiates big and small	36 months
23.	Identifies boy or girl	36 months
24.	Can button clothes	40 months
25.	Combs hair	48 months

* Based on the survey carried out by NIMH team. It should be noted that the time of attainment of a milestone may deviate from the mean age given. For details consult the appendix in the book Mental Retardation - A manual for Psychologists by NIMH.



Walks without support
15 months

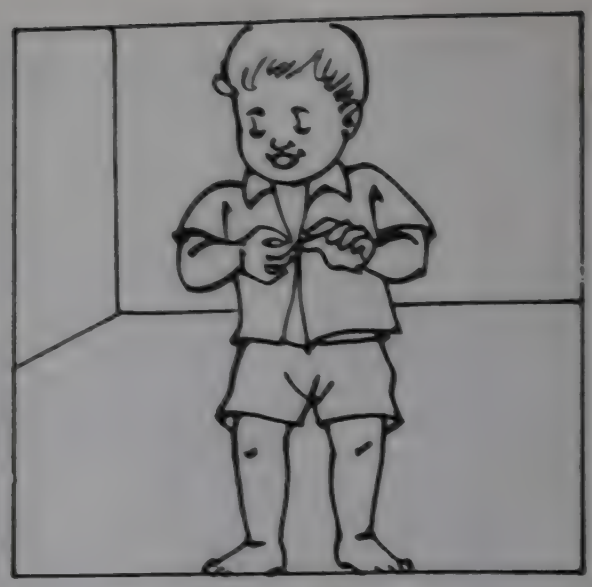
Tells own name
18 months

Drinks by self from a glass
21 months

Shows body parts when named
24 months

Indicates toilet needs
24 months

Speaks in small sentences
30 months



Unbuttons clothes
36 months

Gives meaningful verbal
answers to simple questions
36 months

Differentiates big and small
36 months

Identifies boy or girl
36 months

Can button clothes
40 months

Combs hair
48 months

Identification of persons with Mental Retardation

We have seen how a normal child develops. Early identification of mental retardation is made by seeing how much a child is delayed on the milestones of development. Identification of mental retardation is done by using certain questionnaires or checklists called screening schedules. Three screening schedules are given below. The first is for the children below 3 years of age. The second for those between 3-6 years of age. The third is for those aged 7 years and above. In the description of normal milestones of development, the mean age of attainment alone is given. However, the age range has to be taken into consideration while screening for developmental delays. Hence the age range is given in the screening schedule-I.

Screening Schedule No. 1 (Below 3 years)

S.NO.	ITEM	Normal age range	Milestone delay if not achieved by:
1.	Responds to name/voice	1-3 months	4th month
2.	Smiles at others	1-4 months	6th month
3.	Holds head steady	2-6 months	6th month
4.	Sits without support	5-10 months	12th month
5.	Stands without support	9-14 months	18th month
6.	Walks well	10-20 months	20th month
7.	Talks in 2-3 word sentences	16-30 months	3rd year
8.	Eats/drinks by self	2-3 years	4th year
9.	Tells his name	2-3 years	4th year
10.	Has toilet control	3-4 years	4th year
11.	Avoids simple hazards	3-4 years	4th year
	Other Factors		
12.	Has fits	Yes	No
13.	Has Physical disability	Yes	No

If the child is found to be delayed in any one of the items given from 1-11 and if the child has fits or physical disability, suspect mental retardation.

Screening Schedule No. II (3 to 6 years)

Observe the following:

1. Compared with other children, did the child have any serious delay in sitting, standing, or walking? Yes No

2. Does the child appear to have difficulty in hearing? Yes No

3. Does the child have difficulty in seeing? Yes No

4. When you tell the child to do something, does he seem to have problems in understanding what you are saying? Yes No

5. Does the child have weakness and/or stiffness in the limbs and/or difficulty in walking or moving his arms? Yes No

6. Does the child sometimes have fits, become regid, or lose consciousness? Yes No

7. Does the child have difficulty in learning to do things like other children of his age? Yes No

8. Is the child not able to speak at all? (cannot make himself understood in words/say any recognizable words) Yes No

9. Is the child's speech in any way different from normal (not clear enough to be understood by people other than his immediate family?) Yes No

10. Compared to other children of his age, does the child appear in any way backward, dull or slow? Yes No

If any of the above items is answered 'Yes', suspect mental retardation.

* Adapted from the International Pilot study of severe childhood disability - Final report - Screening for severe mental retardation in developing countries.

Screening Schedule No. III (7 years & Above)

1. Compared with other children, did the child have any serious delay in sitting, standing or walking? Yes No

2. Can the child not do things for himself like eating, dressing, bathing and grooming? Yes No

3. Does the child have difficulty in understanding when you say "do this or that"? Yes No

4. Is the child's speech not unclear? Yes No

5. Does the child have difficulty in expressing without being asked what the child has seen/heard? Yes No

6. Does the child have weakness and/or stiffness in the limbs and/or difficulty in walking or moving his arms? Yes No

7. Does the child sometimes have fits, become rigid or loss consciousness? Yes No

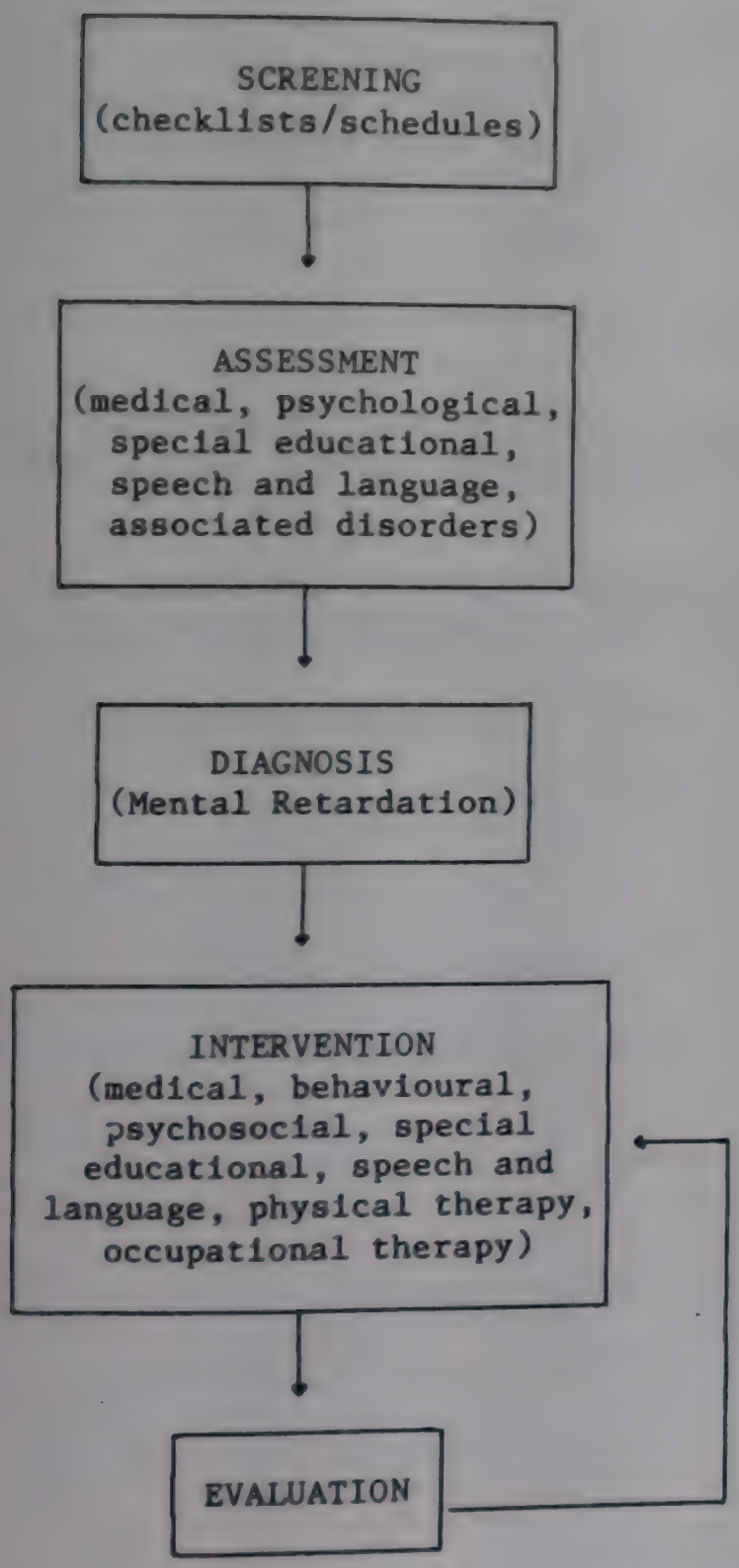
8. Compared to other children of his age, does the child appear in any way backward, dull or slow? Yes No

If any one of the above items is answered 'Yes' suspect mental retardation.

Note: In the screening schedules No.II and No.III, there are a number of questions which are over inclusive i.e. those with hearing handicap or physical handicap or epilepsy alone without mental retardation can be spotted. These two screening schedules ensure prompt identification of every single mentally retarded child. Do not worry if the questions sometimes identify persons with handicaps other than mental retardation. Such persons can be assessed later. Our chief concern is identification of mentally retarded children.

FLOW CHART:

Identification and Management.



Referrals :

Once a case is suspected, the diagnosis of mental retardation should be established by a person who has adequate training in mental retardation. The places where such a diagnosis can be made are the paediatrics/psychiatry departments of general hospitals, mental hospitals, child guidance clinics and special schools for the mentally retarded persons. In addition, the psychologist/vocational guidance counsellor at the District Rehabilitation Centre can confirm the diagnosis. The following information is needed from the parents before arriving at the diagnosis - detailed history about the health of the mother during pregnancy, details of the nature and type of delivery of the child and difficulties encountered if any, details of the health of the child after birth such as immunization and illnesses such as fever, fits, jaundice and measles; and history of similar illness in the family. After eliciting the history, a developmental assessment is done and if needed tests of intelligence are administered. The child is assessed on the assessment checklist to find out the current level of functioning. The child is examined by the medical doctor to find out whether there are any medical problems such as fits. If any drugs are necessary, they are prescribed. A management plan is then drawn out.

The management plan of the mentally retarded child depends upon the current level of the child and the associated conditions such as epilepsy, hyperkinesis, behaviour problems and sensory handicaps. The management plan varies from infant stimulation, training in daily living skills and functional academics to prevocational and vocational skills. Apart from this, help is needed in speech, locomotion, management of problematic behaviour and management of medical problems. The details about management of a mentally retarded person are given in the following chapters. In this manual, management aspects are restricted to parent counselling and guidance, creation of awareness among the public, vocational training and job placement. For details regarding intellectual assessment, skill training and behaviour modification refer to the book "Mental Retardation - A manual for Psychologists".

Summary

1. Twenty five normal milestones of development are described. These items are relevant to Indian situation and are based on a survey carried out by NIMH team.

2. Three screening schedules for the age groups of 0-3 years, 3-6 Years, and 7 Years and above are given. A detailed assessment is needed after screening.

3. The various places where suspected cases can be referred are described.

Self Evaluation - III

1. Match the following:

1. Neck control	a. 8 months	( )
2. Sitting without support	b. 24 months	( )
3. Standing without support	c. 4 months	( )
4. Indicates toilet needs	d. 10 months	( )

2. Give any three indicators of mental retardation:

   a. _____

   b. _____

   c. _____

3. Match the following:

1. Social smile	a. 6 months	( )
2. Drinking from a glass by self	b. 4 months	( )
3. Rolling over	.c. 15 months	( )
4. Walking without support	d. 21 months	( )

4. Arrange the following steps in sequence:

   1. Intervention ( )

   2. Diagnosis ( )

   3. Screening for mental retardation ( )

   4. Assessing current level of functioning ( )

   5. Psychological testing ( )

5. A male child aged 8 months is brought to you with the complaints of inability to hold the head, not able to roll about and not able to fix the eyes on parents. The child cries when hungry. The mother feeds the child periodically. On examination the child is found to be in lying position, not responding to any stimuli. The doctor who examined the child has reported that clinically all the systems are normal. How will you proceed further and what advice will you give the parents.

6. A ten year old boy is brought to you with the complaints of poor scholastic performance and adament behaviour. He is studying in 5th standard. The parents report that the boy scores poor marks in class examinations since one year. He picks up quarrels with other children in the school. He shows interest in games and is found to be playing all the time. The doctor's report says that the boy is normal physically. How will you proceed further in this case.

7. A six year old girl is brought to you with the complaints of inability to talk properly, difficulty in walking, fits once a month and inability to brush teeth, bathe and dress properly. On a detailed enquiry it is found that the girl was born after a prolonged labour and all the milestones of develpoment of the girl were delayed. The doctor has prescribed medicines for fits and the physiotherapist is giving passive stretching exercises for the limbs as the limbs were found to be stiff. How will you proceed further in this case.

CHAPTER - 4

MANAGEMENT

OBJECTIVES :

On completing this chapter the guidance counsellor will be able to

1. List the qualities of a good counsellor
2. Identify the goals of counselling in mental retardation
3. Clarify the common incorrect beliefs about mental retardation
4. List the modes of creating awarness in community on mental retardation
5. List the activities for the welfare of the mentally retarded persons

CHAPTER - 4

MANAGEMENT

After a mentally retarded person has been identified he needs to be thoroughly assessed so that a management plan can be delineated. Generally the assessment and management of a person with mental retardation is done by a team consisting of medical personnel-either a psychiatrist or a paediatrician, a psychologist and a special educationist. The other members may include speech pathologist, physiotherapist, occupational therapist and a vocational guidance counsellor. After a thorough assessment of various aspects including general background information, medical conditions, intelligence, current level of functioning in the day to day living, social competence and associated problems, a management plan is made for the child. This may be either referral to special schools wherever possible, home based training, or vocational training, as the case may be. Before initiating the training programme, the most important point to consider is informing the parents about the child´s condition and honestly telling them what could be done.

Parent Counselling

All parents wish for a healthy and a normal child. However, when a disabled child is born all the hopes of the parents are shattered. This calls for a life long adjustment. In order to assist the parents in dealing effectively with the situation counselling is essential, as a part of the whole management plan. The counselling aims at helping parents understand and accept the child´s problems. This also helps them in making plans appropriate to the capability of the mentally retarded person. To be an effective counsellor one should have certain skills and characteristics. These include:

- Sincerity. The basic quality of a successful counsellor is the sincerity with which he wishes to help the client. This in turn develops trust and confidence in the client. In such a situation parents would come out freely with all the problems they face with the mentally retarded child. It is very important that the counsellor should keep the information about the client and the family situation confidential.

- Reassurance. It is essential to make the parents feel that the counsellor understands them and the problems they face. He should patiently listen to whatever the parents say, even if the information seems unimportant. At the same time he should be careful not to give false hopes to the parents. An effective counsellor would make the client feel reassured and trusting of the counsellor.

- Effective communication. Simple language should be used while counselling and technical language should be avoided. The very purpose is defeated if parents are not able to follow what is conveyed. Honest information on the child´s condition and the various facilities available should be clearly conveyed. However, the final decision regarding management should be left to the choice of the parents.

- Emotional stability. When the parents learn that their child will not become normal, they might get frustrated.They may either breakdown or may become aggressive towards the counsellor. The counsellor should maintain his emotions and must not react adversely to these feelings of the parents. The counsellor should understand that the parents are not upset with the counsellor but with the situation they are facing and are venting their feelings released by their awareness of it. On the otherhand, the counsellor should make the parents feel relieved of the anxiety and frustrations, they had been lodging for a long time.

The focus of counselling depends upon the individual needs of the mentally retarded child and his family. The following are the stages of counselling the parents of a mentally retarded person.

STAGE 1 Impart information regarding the condition of the mentally retarded child

- The child´s actual condition should be explained in simple words to the parents.

- Enough time must be taken while counselling.

- Misleading, giving false information or building false hopes in parents must be avoided.

- Information regarding professional help for treating associated conditions like fits, hyperactivity, or other handicaps must be made available to the parents.

STAGE 2 Help the parents to develop right attitudes towards their handicapped child

- Many a time the parents tend to have wrong beliefs, attitudes and ideas regarding the causes and management of the disabling condition of their child. This is especially true with mental retardation because the child usually looks ´normal' and yet functions subnormally. Because of the lack of awareness, the parents tend to believe that the child would become normal in due course of time. If they are aware of the problem, some parents blame each other for being responsible for the birth of such a child due to lack of awareness on causes. Some parents look either for medical and surgical cures or magical cures through faith healing. Some even feel that nothing could be done for such a child.

- The counsellor should give correct information on the the nature, causes and management of mentally retarded persons. He should give suitable examples of the other persons with mental retardation and how they are managed.

- Some parents have faulty attitudes towards their mentally retarded child. This may be either over protection or rejection.

- Attitudes such as overprotection i.e. shielding the child from any challenging situation and/or doing almost everything for the child before he fully attempts to do them should be corrected as it hinders the development of whatever capacities the child may have.

- The attitude of rejection,that is, thinking that the child is good for nothing and ignoring him should be changed so that the child can be helped to learn by systematic training.

- Some parents push their child too hard expecting him to learn or achieve beyond his abilities. This may lead to frustration and failure in the mentally retarded child. The parents should be made aware of what they may expect of their child.

- Some parents suffer from guilt feelings that they are responsible for their child´s condition. The parents should be explained that the condition of mental retardation is generally due to causes over which parents have no direct control.

STAGE 3 Create awareness in educating the parents regarding their role in training their mentally retarded child

- Once the parents bring their child for consultation, they tend to believe that the management of the child will be taken care of by the persons working for the mentally retarded. The counsellor should explain the effectiveness and role of the parents and other family members in training the mentally retarded child.

- Some parents believe that training a mentally retarded child needs specialized skills and they may not be able to train their child. The parents should be made aware that training a mentally retarded child does not need complex skills and with repeated training in simple steps, the mentally retarded child can learn.

- Meeting of the parents of mentally retarded children who are already being helped, with the parents of mentally retarded childern who are newly identified will be helpful. This will also offer them opportunities for mutual support.

- Parents should be helped to learn the skills in training their child through demonstrations and observations.

- Parents should be demonstrated how their training has helped the child to acquire some skills. This will develop a sense of achievement in the parents, making them more involved in the training of their mentally retarded child.

Some Questions Parents ask.

Misconceptions are incorrect ideas held by any person with regard to any condition. Such misconceptions about mental retardation may be present in the parents or the general public.

Measures taken by the parents in managing the problems of their mentally retarded child will depend upon the ideas they hold about the condition. The amount of cooperation one would receive from the parents in the training of the mentally retarded child is related to the amount of correct knowledge the parents have about mental retardation. The following questions and answers will help you in telling the parents what mental retardation exactly is.

1. Is mental retardation same as mental illness?

No. Mentally retarded persons are not mentally ill. The mentally retarded persons are just slow in their development. Therefore, they are dull and slow in understanding and have difficulty in learning various skills needed for daily living. Usually they have problems in speech. Some of them can be educated up to the 5th class while the others cannot reach even this level.

The mentally ill, on the other hand have normal development. Mental illness can occur at any age even among the highly qualified people. Mental illness can be generally cured.

2. Is mental retardation curable?

No. Mental retardation is a condition which cannot be cured. But timely and appropriate intervention can help the mentally retarded person to learn several skills.

3. Can marriage solve the problems of mental retardation?

No. Many people think that after marriage, the mentally retarded person will become active and responsible or sexual satisfaction will cure the person. That is not so. Marriage will only further complicate the problems. When it is known that a mentally retarded person cannot be totally independent, it will not be possible for him/her to look after his/her family.

4. Do mentally retarded persons become normal as they grow older?

No. The mentally retarded person´s mental development is slower than that of a normal person. Therefore, when their actual age increases with time, the mental development does not occur at the same pace to catch up with the actual age. The mentally retarded persons cannot become normal as they grow older, but, with intensive training they can improve to some extent. Early training is very important.

5. Ismental retardation an infectious disease?

No. Many people think that on allowing normal children to mix, eat or play with mentally retarded children, the normal children also develop mental retardation. This is wrong. Inter action between mentally retarded children and normal children on the other hand, helps in the improvement of mentally retarded children. Also normal children will understand the problems of the retarded children and will accept them.

6. Is it true that the mentally retarded persons can not be taught anything?

No. Mentally retarded persons can be taught many things. They can learn to look after themselves; to do tasks such as watering the plants, sowing the seeds, looking after the cattle, sweeping the floor, cleaning the utensils and carrying the loads. The mentally retarded persons have to be trained systematically. They can perform many jobs under supervision.

7. Is it true that mental retardation is due to karma and hence nothing can be done about it?

No. Believing that mental retardation is due to their karma helps the parents to be free from the feelings of guilt. But having this belief and making no efforts to train the child and leaving the child to fate is not correct. Parents must be told that whatever may be the cause, training the child will improve him/her. The earlier the training is started, the better the chances of improvement in the child.

Parent guidance and counselling forms an important aspect of the management of mentally retarded persons. To help the parents gain the support of the persons in the community and also to mobilise the community to participate in the habilitation Programmes the mentally retarded persons, awareness programmes should be undertaken. Bringing about an awareness in the community about mental retardation is an important aspect in the total care of the mentally retarded persons. In fact, in the organization of the Community Based Rehabilitation Services, bringing an awareness about the condition is a primary step. Aspects of community awareness in mental retardation are given below, with an introduction about the status of awareness in the past.

Community Awareness

For centuries, the mentally retarded individuals were ignored, ridiculed, avoided, negelected, or persecuted by society. In a few societies they were either tolerated or were even revered. In some societies mentally retarded were considered to be subhuman.

In the middle ages, they were attached to the royal courts where they earned favours as fools or court jesters. In France they were known as 'Childern of God' and considered to be sacred. The same attitude was seen among the American Indians. German theologists were under the opinion that they were 'Full of satan'. Depending upon the ignorance or superstition of the then existing times the mentally retarded persons were treated respectfully or cruelly but always differently.

There were some attempts made to take care of the mentally retarded persons during the time of King Edward II of England (1325). However these did not last long. In the seventeenth century, 'Work Houses' were established through out Great Britain as a way of meeting the needs of the mentally retarded, aged, orphaned and mentally ill persons. However, public apathy towards these disabled persons diminished after World War II. In 1848 Edward Seguin spread his philosophy that Education is an universal right and that all members of the society, including the mentally retarded persons are entitled to an improved life situation. The sucess or failure of the mentally retarded persons actually depends on being accepted or rejected by the society.

The word mental retardation is not properly understood by the society even in this century. It is the duty of all the professionals concerned and particularly the vocational guidance counsellors to make the society understand the condition of mental retardation and the needs of mentally retarded persons. The society should be made aware of the urgent need to recognise the mentally retarded persons and give optimum care to make them as independent as possible and make them a part of the society.

An awareness regarding mental retardation amongst the society should be brought about on a large scale. Every person in the society should be made aware of the ways in which he should act and interact towards the mentally retarded, and the ways in which he has to modify his behaviour and attitudes to help the mentally retarded to become a part and parcel of the society.

This awareness can be brought about making concrete impression on the minds of the members of the society, so that they may discard inhibitions, misconceptions and superstitions about the mentally retarded persons.

The vocational guidance counsellor or any other professional who is dealing with mental retardation should think of the various methods of communication to bring about this awareness.

Awareness could reach both the illiterate and the literate population through clear illustrations in the form of posters. These posters should cover all the essential aspects of information regarding mental retardation.

One can reach the population through radio, television and short films to bring about the awareness. In a rural setting, 'radio' is the best medium of imparting information as it is the cheapest and most prevalent medium of communication. This information can be given in regional languages. Television is another popular medium which can be effectively used. Television appeals to the common man as it is the most convenient and easy mode for entertainment and knowledge. Television fillers in between popular programmes or short films in the form of interesting stories may be thought of. These methods of creating awareness however lie with the planners at the State and National level and not with the vocational guidance counsellor at the district level.

The public tend to absorb the messages put forth on the ecreen and register the ideas in their minds for a long time. Slide projection with commentary and short films which can be projected in the rural areas are the ways of impressing the minds of semi-literates. A vocational guidance counsellor should explore the areas in his district which can serve as vital points in spreading the message about mental retardation. The vocational guidance counsellor can take the examples from other awareness programmes such as those for family welfare programme and immunization in children for spreading the message about mental retardation.

A vocational guidance counsellor's job is not only to make the community aware of the problem of mental retardation. It is the first step he has to take in helping the mentally retarded persons. It is not enough for the society just to be aware of mental retardation, but it also should participate in every possible way to help these retarded people to become as normal as possible. This can be achieved by forming groups of parents of the mentally retarded children and make them work towards the ultimate goal of normalization. Normalization means, the use of progressively more normal settings and procedures to establish and maintain the behaviour of the mentally retarded persons, which are culturally as normal as possible. They should be both physically and socially integrated into the society to the maximum extent possible, regardless of the degree of retardation.

Since three decades, many associations for the welfare of the mentally retarded persons were formed by the parents and other interested individuals. In India, organised parent associations have come into existence in the seventies and the eighties in all big cities. There are associations at National level too. The vocational guidance counsellors should help the parents to form small groups in each region and work towards the betterment of the retarded. In turn these groups can become members of bigger associations at the National level. It is therefore, imperative to work with parents while the parents' associations work with the large group - the 'Community'

As the parental attitudes are a result of community group pressures, the vocational guidance counsellor must foster group approaches which are organised, directed and channelized for therapeutic ends. The feeling of belonging to a group of parents whose problems are similar and are being handled by their own resources and means has a great therapeutic value.

The parents can be given training not only in dealing with teaching techniques, but also in resolving the problems of their children and in coping skills. Thus group guidance becomes a tool in integrating the retarded into the community.

The vocational guidance counsellor can also help in developing 'Service stations' in rural setting where the parents who are illiterates and belong to labour class can obtain guidance. The vocational guidance counsellor should tap the resources available in the rural community. Identification of potential persons in the community followed by short term training in management of the mentally retarded in that community is the basic idea of the service station. The vocational guidance counsellor can arrange for the itenerant services from nearby cities to supplement the services needed as and when necessary. Thus a dedicated involvement of a vocational guidance counsellor is essential in making the society aware of problems of the mentally retarded persons and to make the community work towards normalizing them.

Summary

1. The role of the vocational guidance counsellor in the management of mentally retarded persons is explained.

2. Parent counselling is an important aspect of the management of a mentally retarded person.

3. A counsellor should be sincere, reassuring, communicate effectively, and stable emotionally. The counselling should always be non-directive.

4. The steps in parent counselling are imparting information regarding the condition of the mentally retarded child, helping the parents to develop the right attitudes towards the mentally handicapped child and educating the parents regarding their role in training their mentally retarded child.

5. Some of the common questions parents ask about mental retardation and the appropriate answers are given.

6. The society should be made aware of the need to recognize the mentally retarded persons and give enough care to make them as independent individuals as possible.

7. The common popular modes of reaching out to the society to create awareness about mental retardation are radio, television, slide projection and posters at strategic points.

8. Society is responsible to integrate the mentally retarded persons both physically and socially into the community to the extent possible regardless of the degree of retardation.

Self Evaluation - IV

1. The characteristics of a good counsellor are

   a. _____

   b. _____

   c. _____

   d. _____

2. List four important messages which you would give to the parents of a mentally retarded child in a rural area.

   a. _____

   b. _____

   c. _____

   d. _____

3. Study the following statements carefully and say whether they are 'True' or 'False'

   a. Parents should be given high hopes that the mentally retarded child will show dramatic improvement True/False
   b. Lot of time must be spent in understanding the problems of the parents. True/False
   c. The goal of counselling is to protect the mentally retarded child from being ill-treated. True/False
   d. Forming parent associations in the villages will help the parents to understand the problem better. True/False

4. Write four common misconceptions about mental retardation held by the people in your area.

   a. _____

   b. _____

   c. _____

   d. _____

5. What are the four common methods you would employ in creating awareness about mental retardation in your area.

   a. _____

   b. _____

   c. _____

   d. _____

6. List the social benefits offered by the government for the mentally retarded persons in your state

CHAPTER-5

VOCATIONAL TRAINING AND JOB PLACEMENT

OBJECTIVES :

On completing this chapter the guidance counsellor will be able to

1. Assess a mentally retarded person for vocational training
2. Identify various jobs in which a mentally retarded person can be placed.

CHAPTER- 5

VOCATIONAL TRAINING AND JOB PLACEMENT

The ultimate aim of education and training of the mentally retarded persons is social and occupational adjustment in adult life. A good and effective guidance programme is essential for appropriate vocational training and job placement. Such a guidance programme must not only take into consideration, the assets and deficits of the retarded person, but also the whole family and the resources available in the family and the community.

Before placing a person with mental retardation in a job, his readiness for work must be considered. A simple checklist to assess the individual's readiness including independence in daily living skills, social skills. consideration for others, trustworthiness, reaction to superiors/authority, functional academic skills, ability to manage time and money, work ability, behaviour and health conditions must be prepared. A sample of such a checklist which is under field trial at NIMH is given at the end of the chapter. The mentally retarded persons have certain basic limitations in reasoning and judgement and find it difficult to understand abstractions. The vocational training programme must be planned keeping in view these points.

The types of job varies according to the resources in the community and the ability of the mentally retarded person. In rural areas, the mentally retarded individuals may be involved in farming, keeping bees, poultry, dairy farms and simple service jobs. In urban and industrial areas, simple factory jobs such as errand boys and elevator man, helpers in the shops, and other semi or unskilled jobs will be suitable for them.

The professionals must be aware of all suitable employment opportunities in the community. They should maintain links with village heads and other key persons who would enable them to place the mentally retarded persons. They must provide assistance to the retarded person and his family in a) choosing the field of employment, b)finding specific job, c) meeting legal requirements if minors are employed, d)educating the employer regarding the mentally retarded person and e) helping the retarded person, his family and the employer in solving problems which occur in the employment situation.

Satisfactory job placement will be possible only if the job requirement and the concerned retarded person's ability are matched. The professional has an important role in learning both these details and planning of placement. The vocational guidance counsellor should do a thorough analysis of the job as well as the suitablity of the retarded person to fit in before placing him/her.

For instance, assembling jobs require the ability to carry out directions and copy models exactly. It requires steadiness of control. On the other hand, errand jobs require sufficient ability to comprehend and carryout written or oral instructions. Folding and packing small items require fine motor skills and neatness and precision. Thus each job requires skills specific to the job and therefore the mentally retarded person must be appraised for his abilities and then placed on a job.

Regular follow up is extremely important after placing a mentally retarded person in a job. Many retarded persons, though found to be very good at work output, fail to retain their jobs because of the lack of social competence. Inability to adjust with co-workers, not being punctual, irregularity and maladaptive behaviour are some of the reasons for losing the jobs. The follow-up would give definite evidence of many factors that contribute to the success or failure of a mentally retarded person in the job.

Some of the factors that contribute to the success of the retarded person's job are aptitude, physical stamina, emotional maturity, and social competence. Mentally retarded persons are more sucessful in jobs involving simple repetetive operations than those where they have to make decisions or change activities frequently. Good home conditions also aid in satisfactory job adjustment. Convincing the employer of the ability of the retarded person and the procedure for training him with repeated instructions and reinforcement also leads to successful placement of retarded persons.

The possible settings in which a mentally retarded person may work are three, namely, self employment, sheltered employment and open employment. The type of setting a person would fit in, would depend upon, his level of retardation, aptitude & resources at home and in the community, in which he lives. The vocational counsellor should take into consideration all these aspects before placing a mentally retarded person in a job. The details of the various settings are as under.

Self Employment It has been the experience of some of the voluntary organizations that a retarded person with a motivated parent/caretaker can be self employed and earn. In such circumstances, the kind of jobs identified for them are such that they have an outlet for the product made in the immediate surroundings. For instance, small covers made at home by mentally retarded adults can be sold right away to a nursing home in the neighbourhood so that they can be used for dispensing tablets to patients. Similarly articles like agarbathi made by them at home can be sold by them in the community.

Sheltered Workshop A more structured job training is given in this setting where skills are imparted in assembling, sorting, light engineering, packaging and so on. This requires a workshop with qualified staff to train them. This would also require a specific period of vocational training and workstation training or on-the-job training. The products are made here on contract, for various companies from where raw materials are received and finished products returned. The retarded adults are paid for their labour. Here they are required to follow discipline and routine.

Open Employment The retarded persons are placed on a job like any other normal person and they get paid in a similar manner. Such jobs include, office boys, lift operators, restaurant table cleaners, house maids, gardeners and so on. In a rural setting informally,the mildly retarded persons are absorbed in semi-skilled and unskilled jobs without coming to be known as mentally retarded.

A list of suitable jobs for the mentally retarded persons extracted from the National Employment Services, National Classification of Occupations (NCO, 1968), Ministry of Labour Employment and Rehabilitation, Government of India is given below. The list is condensed and jobs which may be performed by a mentally retarded person only are given. The vocational guidance counsellor should be careful in matching the job for a particular person. He may also take this as a guideline for exploring local resources to find a suitable job for the mentally retarded persons.

S.No.	GROUP	TYPE OF JOB
1.	Clerical and related workers	1. Dusting man, office, Farash (Performs unskilled duties in office such as dusting of rooms and furniture, opening and closing of office, etc.,)
		2. Lift operators.
2.	Dairy workers	1. Dairy Attendant (Feeding animals, cleaning and disinfecting buckets and other containers)
3.	Salesmen, shop assistants and related workers	1. Backroom attendant
4.	House keepers, matrons and stewards	1. Linen Keeper 2. Kitchen porter, 3. Helpers in kitchen work
5.	Butlers, bearers and waiters	1. Bearer, Waiter, (Domestic)
6.	Ayahs, nurse maids	1. Ayah, Maid (Domestic)
7.	Hair dressers, barbers	1. Saloon Boy
8.	Service Workers	1. Caddie (golf court)
9.	Farm Workers, animals birds and insect rearing	1. Herdsman 2. Grazier 3. Milker (Hand) 4. Milking machine operator 5. Dairy Farm Workers involved in farm live stock for milking, cleaning,feeding etc.
10.	Other Farm Work	1. Grass cutter

S.No.	GROUP	TYPE OF JOB
11.	Harvesters and gatherers of forest products	1. Gatherer (Fire wood) 2. Cane cutter 3. Thatch cutter
12.	Sawyers, plywood makers and related wood processing workers	1. Workers (perform low skill tasks such as holding timber while sawing,feeding boards and planks against cutter.) 2. Sawyer helper
13.	Fibre preparer	1. Mixing attendant 2. Waste Picker 3. Wool carrier
14.	Crushers and pressers oil seeds	1. Oil crusher operator (animal powered) 2. Filter press operator
15.	Khandasari, sugar and gur makers	1. Raw juice tank pump attendant. 2. Food preservers Grader Washer
16.	Bakers, confectioners, sweetmeat makers and other food processors	1. Helper - Milk room attendant
17.	Tobacco preparer	1. Tobacco stripper 2. Beedi making
18.	Tailors and embroiders	1. Button hole makers 2. Eyelet holing 3. Tailor assistant
19.	Shoe cutters, and related workers	1. Cutter (hand) 2. Sole presser 3. Stapling machine operator (foot wear)
20.	Carpenter, cabinet makers and related workers	1. Fret saw machine operator 2. Jig saw machine operator 3. Picture frame maker operator 4. Wood lacquerer

S.No.	GROUP	TYPE OF JOB
21.	Metal polishers and tool sharpeners	1. Polisher
22.	Machinery fitters and machine assemblers	1. Assembler, continuity assembling work in factories 2. Assembler - bicycle
23.	Plastic product maker	Plastic product making operations 1. Arranging and loading plastics or plastic inmpregnated sheets. 2. Cleaning and finishing moulded plastic products. 3. Laminating press helpers 4. Plastic sheet finishing press operator
24.	Book binders and related workers	1. Book binding 2. Cutting paper to specified size 3. Ruling blank sheets 4. Applying gum
25.	Painters, spray and sign writing (stencil)	1. Painter - spray 2. Painter - brush 3. Painter - wood work and furniture.
26.	Basketery weavers and brush makers	1. Caner 2. Basket maker 3. Mat weaver, bamboo 4. Broom maker
27.	Construction workers	1. Distemperer 2. White washer
28.	Oilers and greasers and cleaners	1. Cleaners Motor vehicle 2. Greaser

The various jobs suitable for the mentally retarded, as described above may not be available at every place. As already described, the vocational guidance counsellor should study the area in which the mentally retarded person lives and explore for suitable jobs.

A checklist to assess the prevocational level of a mentally retarded person is given below. A mentally retarded person should be functioning independently in many areas before being considered for work either in the self, sheltered or open employment. The broad areas and the items under each area are given in the checklist.

Checklist for Prevocational Level*

Instructions for Use

To assess the level of performance of the mentally retarded persons in a particular skill, read each item under the various skills carefully and select the code - I, C, VP, PP, TD, or PI which best describes the present level of performance. The details of the codes are as under:

I - Independent
C - Needs cueing
VP - Needs verbal prompting
PP - Needs Physical prompting
TD - Totally Dependent
PI - Physically Incapable

Record your answer in the checklist in the appropriate place. Achievement of independence i.e., marked 'I' on a specific skill will be considered as pass criterion of that particular skill. The score 'C' may be considered as pass for a particular skill. However, this skill has to be strengthened. An achievement of 80% in all the skills will be considered as pass in the prevocational level, which will make the person fit for vocational training.

A person with motor problems may not achieve 80% of the skills in the motor area. Similarly a nonverbal person will not be able to score on items such as 'communicates properly in sentences or 'engages in meaningful conversation with two or three persons', but he/she may communicate with gestures. Evaluate such non ambulatory and nonverbal persons accordingly. Similar allowance can be given for academic skills for a moderately/severely retarded person.

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* At the time of printing, this checklist was under field trial at NIMH. Some of the items may either be modified or deleted based on the results of the field trial. Some items need to be qualified further. This checklist is intended to be a guide for the vocational counsellor to assessa mentally retarded person at the prevocational level.For details of the field trial please contact Ms. Thressia Kutty and Mrs. Jayanthi Narayan, N.I.M.H.

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Checklist for Prevocational Level

	Entry Level	Formative Level 1	2	3	4	Summative Level	Remarks
Date:							
I. Motor Skills :							
1. Skips							
2. Hops.							
3. Plays outdoor games (football).							
4. Takes part in sports running jumping, throwing etc.).							
5. Plays indoor games (eg. caroms)							
6. Catches/picks up small moving objects.							
7. Stitches a button.							
8. Copies any line picture.							
9. Can sand paper a given surface. (qualify)							
10. Rides a bicycle.							

	Entry Level	Formative Level 1	2	3	4	Summative Level	Remarks
Date:							
II. Self Help Skills :							
1. Anticipates needs and uses the toilet appropriately.							
2. Maintains cleanliness unaided (brushing, bathing, combing).							
3. Menstrual hygiene/shaving							
4. Eats properly observes manners in a family situation without supervision.							
5. Orders for food and eats in a restaurant.							
6. Manages dressing unaided and maintains a neat appearance.							
7. Selects clothes from a shop.							
8. Uses dettol and bandage on a cut.							
9. Takes medicine as per time schedule.							
III. Communication Skills :							
1. Verbal communication assisted by gestures.							
2. Communicates using words only.							
3. Gesturally/verbally makes himself understood by others.							
4. Communicates properly in sentences.							

	Entry Level	Formative Level 1	2	3	4	Summative Level	Remarks
Date:							
5. Listens and comprehends what is told to him.							
6. Engages in meaningful conversation with 2 or 3 persons.							
IV. Social Skills :							
1. Greets peers and elders appropriately.							
2. Offers help when needed, without prompting.							
3. Co-operates in group situations.							
4. Behaves acceptably and welcomes the visitors.							
5. Recognizes and protects his own property.							
6. Asks permission to use the property of others.							
7. Maintains acceptable behaviour in a given situation.							
8. Leads peer group in simple activities.							
9. Identifies various places in the community (toilet, theatre, hospital, post office, bank)							
10. Behaves appropriately in the presence of a person of the opposite sex.							
11. Aware of the right of voting.							
12. Tells the name of the city and country.							

	Entry Level	Formative Level 1	2	3	4	Summative Level	Remarks
Date:							
V Academic Skills :							
1. Understands 10 significant signs and words (poison, men, women, hot, cold, stop, danger, toilet in, out).							
2. Reads and comprehends simple sentences.							
3. Writes simple sentences.							
4. Writes a letter and address on envelope.							
5. Has number concept up to 100.							
6. Does single digit additions.							
7. Does two digit carry over additions.							
8. Does single digit subtractions							
9. Does two digit carry over subtractions (up to 20).							
10. Does simple multiplications							
11. Does simple divisions							
12. Uses a measuring tape							
13. Weighs objects using weighing scale up to 100 grams							
14. Dispenses liquid using measuring cups.							
15. Makes purchases and gets balance for 5 rupees.							
16. Tells hours 30 mts,15 mts, and 45 mts.on a clock.							
17. Tells time to the minute on the clock.							
18. Associates time with the work routine.							
19. Understands that money is paid for work.							

	Entry Level	Formative Level 1	2	3	4	Summative Level	Remarks
Date:							
20. Can operate a simple bank account.							
VI. Vocational Skills :							
1. Aware of the hazards in the environment (careful in handling a blade,hammer,saw, pike, chistle, exposed wires etc)							
2. Uses household electrical items safely (iron,table light,water heater)							
3. Sweeps the floor without supervision.							
4. Dusts the furniture neatly.							
5. Washes and dries clothes.							
6. Irons the clothes.							
7. Prepares and serves a simple meal.							
8. Buys the necessary things for cooking if listed and given.							
9. Attends to an assigned task without disturbing others for 1 hour.							
10. Goes to an assigned area without reminder in a routine daily programme							
11. Understands and completes a task in order to receive money.							
12. Leaves residence so as to reach the place of work/activity.							
13. Aware of basic traffic rules.							
14. Travels by bus independently.							
15. Fills an application form with the necessary details.							

Assessment at the Prevocational Level

Sl.No.	Area	No.of Skills	No.of Skills Achieved.					
			Entry Level	Formative Level 1	2	3	4	Summative Level	Remark
			Date:						
1.	Motor Skills	10							
2.	Self-Help Skills	9							
3.	Communication Skills	6							
4.	Social Skills	12							
5.	Academic Skills	20							
6.	Vocational Skills	15							
	T O T A L :	72							

The mentally retarded persons at the prevocational level are expected to achieve 80% of the above skills for On- the-job-training.

Summary

1. The ultimate aim of training a mentally retarded person is to make him as independent as possible and in case of mild or moderate mental retardation, to make them earn their livelihood.

2. Each mentally retarded person must be assessed for his readiness for work before training him in a job.

3. The mentally retarded persons can work under three different settings - self employment, sheltered workshop and open employment.

4. The list of jobs suitable for the mentally retarded are given .

5. A checklist to assessthe mentally retarded persons at the prevocational level is given.

Self Evaluation - - V

1. Study the following statements carefully and say whether they are 'True' or 'False'.

   a. All the mentally retarded persons can be placed in jobs. True/False

   b. A mentally retarded adult with frequent fits should not be placed in a job involving cutting tools and machinery. True/False

   c. Mentally retarded persons cannot be given a vocation in rural areas. True/False

   d. A mentally retarded person should be trained for sometime in the type of job he will undertake before the actual job placement. True/False

   e. Periodic follow up by the vocational guidance counsellor will help in the job adjustment of the mentally retarded person. True/False

   f. A mentally retarded adult must be independent in self-help skills before he is considered for vocational training. True/False

2. List six important areas in which a mentally retarded person must be assessed before he is taken up for vocational training.

   a. _____ d. _____

   b. _____ e. _____

   c. _____ f. _____

3. What are the various settings in which mentally retarded person can be placed for jobs.

   a. _____

   b. _____

   c. _____

* * *

Answer Key

Self Evaluation - I

1. a. Significantly subaverage general intellectual functioning

   b. Impairments in adaptive behaviour

   c. Manifestation during the developmental period.

2. 2%

3. a. Methodology

   b. Type of population studied

   c. Definition of mental retardation

4. a (3)

   b (1)

   c (4)

   d (2)

5. Match the following

   a (2)

   b (3)

   c (4)

   d (1)

6. True or False

   1. True

   2. False

   3. False

   4. True

   5. False

Self Evaluation - II

1. b

2. b

3. c

4. a. Immunization of children

   b. Adequate nutrition to children

   c. Prompt control of high fever in children

   d. Immediate control of fits in children

5. c.

6 c.

7. a. Early infantile autism

   b. Child with emotional disturbance

   c. Specific learning disabilities

   d. Child with hearing and or visual handicap

8. b.

Self Evaluation - III

1. a (2)

   b (4)

   c (1)

   d (3)

2. a Delay in milestones of development

   b Fits or physical disability

   c Poor scholastic performance

3. a. (3)

   b. (1)

   c. (4)

   d. (2)

4. 3-5-4-2-1

5. Start with infant stimulation programme. Stimulate the child with visual, auditory and tactile stimulite. Train the child in motor skills. Refer to a special educationist (or psychologist at the DRC) a physiotherapist and a speech pathologist for necessary follow up advice.

6. This boy may not be mentally retarded as he was normal till 9th year. The boy should be referred to a psychiatrist for detailed examination as he might have some psychological problems resulting in the poor scholastic performance.

7. The current level of functioning has to be assessed and a management plan has to be drawn out to train the child in self help skills and communication skills. The child should be sent for regular follow up to the doctor and the physiotherapist

Self Evaluation - - IV

1. a. Sincerity

   b. Reassuring

   c. Effective communication

   d. Emotional stability

2. a. With training a mentally retarded person will improve

   b. Mental retardation is not infectious disease

   c. There are a number of causes which can be prevented

   d. Step by step training is the key to success. Do not lose hope if you are not able to achive results in a short time.

3. a. False

   b. True

c. False

d. True

4. List the misconceptions prevalent in your area and correct them.

5. a. Posters

b. Short films

c. Slide shows

d. Slides in cinema halls

6. List the benefits offered by your state government. The railways give concessional ticket to travel by train to the mentally retarded persons and their escorts.

Self Evaluation - V

1. a. false

b. True

c. False

d. True

e. True

f. True

2. a. Motor skills

b. Self help skills

c. Communication

d. Social skills

e. Functional academics

f. Vocational skills

3. a. Self employment

b. Sheltered employment

c. Open employment